No. 88-1125

In the Supreme Court of the United States

OCTOBER TERM, 1989

JANE HODGESON, ET A.L.,
APPELLANTS

V.

MINNESOTA, ET A.L.
APPELLEES

PETITION FOR A WRIT OF CERTIOARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

BRIEF FOR HERBERT RATNER, M.D.
AS AMICUS CURIAE SUPPORTING APPELLEES

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

Herbert Ratner, MD is a past eighty public health specialist who has taught at the University of Michigan and University of Chicago Medical Schools. He founded the La Leche League. He has been a public health officer of a city. He resides in Illinois and publishes Child and Family Magazine.

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SUMMARY OF ARGUMENT

This brief argues that this Court's experiment with freedom of sex has caused America more damage than all our wars combined. Those infected with sexually transmitted diseases number more than the casualties in all our wars. Those killed by sexually transmitted diseases will soon exceed those killed in all our wars. The economic cost of the right to privacy and destruction of the right to prevent pornography from influencing the young exceeds the cost of all our wars and exceeds the national debt. The other costs include a lack of commitment best illustrated by abortion which has caused our divorce, illegitimacy and numerous related undesirable rates to skyrocket. Amicus suggests the Court call of the war on America by reversing the right to privacy and the right to abortion.

SEXUALLY TRANSMITTED DISEASES

Both primitive and later societies which have adhered to nature's script and in which lifelong faithful monogamy was accepted as nature's norm have been notably free of sexually transmitted diseases. In societies in which sexual morals became lax and the sensual and erotic life became an end in itself, multiple sex partners were commonplace, abortions abounded, perversions prevailed, sexually transmitted diseases were common, an anti-child mentality developed, and the family as a functioning unit broke down.

Today, western man is undergoing a catastrophe of even greater proportions. Society is presently characterized by infidelity to family, country and religion, dissension between man and woman, single parent and broken homes, insecure childhood carried over to insecure adulthood, sex without norms, rampant sexually transmitted disease including an unusual increase of new ones, a sharp increase in the incidence of sterility, seemingly uncontrollable drug misuse, and a growing disregard of the value of life as seen in abortions on demand and in the promotion of infant and adult euthanasia under the principle that some people are better off dead.

The media is partially responsible but this Court gave the media freedom.

The damage done to the US in just a few years by the sexual freedom granted to America by this Court is approaching and will soon exceed the damage done by all our wars. The wars have caused over a million deaths and a few million wounded. The sexual revolution has caused far more wounded and in a few years more deaths.

In 1982 the Federal government spent 125 million dollars on family planning services through the Public Health Service Act alone with more money spent through other programs. Despite growing expenditures of funds on family planning services, the problem of teenage pregnancy has remained intractable. The number of conceptions for example rose 14% between 1974 and 1979, and the percentage of out-of-wedlock babies born to teenagers tripled between 1960 and 1980. It seems clear that throwing money alone at the problem is not going to solve it.

Kingsley Davis, Professor of Sociology at the University of California, Berkeley, said in 1972, "The current belief that illegitimacy will be reduced if teenage girls are given an effective contraception is an extension of the same reasoning that created the prob-

lem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties."

"The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable." U.S. Commission on Population Growth and the American Future - 1972.

The second medical problem area is S.T.D., Sexually Transmitted Diseases. The reported incidence of gonorrhea in the United States has hovered around one million per year in recent years and seems to be leveling off, massive underreporting is a recognized fact. As startling as this figure is the rate of chlamydia infections is thought to be 2-3 million cases per year. This infection

is very difficult to diagnose as the offending bacteria only grow in human cells. Among the major non AIDS sexually transmitted diseases are gonorrhea, genital herpes, cytomegalo virus, chlamydia, T-myco plasma, hepatitis B, syphyllis, trichomonas, crab lice, and genital warts.

Another S.T.D. of viral etiology is genital warts. While this condition is curable, it is evident today that certain varieties of the human papilloma virus, the offending organism, are responsible for the third medical problem noted earlier, cervical intra-epithelial neoplasia, CIN, no pun intended. Others have noted that the first fallout from the sexual revolution, was a tremendous upsurge in the rate of venereal disease. Now evidence from several quarters suggests an alarming second wave of fallout;

a sharp increase in the incidence of cancerous and pre-cancerous lesions of the cervix among teenagers and young women.

All data herein is from US Covernment Sources, the CDC, NIH or US Vital Statistics.

AIDS, the most frightening and deadly sexually transmitted disease, has killed about 60,000 Americans according to the official body count. Unfortunately, many deaths from AIDS probably go unreported because of the connotation involved when death from AIDS is reported. Far greater than today's AIDS death count is what we expect in the near future. Over 100,000 have been diagnosed as having AIDS symptoms and they can be expected to live only short time. The number believed infected exceeds one million, and most of these are expected to be killed by the

disease before the year 2000.

Other sexually transmitted diseases also take a toll. At the end of the second World War, there were five known sexually transmitted diseases. Now there are fifty. One of these which many have not even heard of, causes about 10,000 deaths annually. The STDs cause far more deaths than those credited to them because of under reporting. Cervical cancer, as one example among many, is far more frequent than a generation ago. Why? The increase is among those women who have had certain sexually transmitted diseases. The disease makes the cervical area more likely to develop cancer. These deaths are blamed on cancer, not the sexually transmitted diseases which are a proximate cause. Again and again we see that the risk factors are early commencement of sex, frequency of one

night stands, number of partners, and the other factors which are more frequently found in the "sexually liberated".

Each of the sexually transmitted diseases causes great harm, but this Brief will limit itself to selected detailed information in Appendix 1, "The Economic Cost of Pelvic Inflammatory Disease" by Washington, Arno and Brooks, JAMA, 4/4/86, Vol 255, No 13, p1735-1738 and Appendix 2, "'Silent Epidemic' of 'Social Disease' Makes STD Experts RAise Their Voices", JAMA June 23/30, 1989, Vol 261, No 24. Many similar sources could be quoted and can be found on the JAMA or NIH indices.

In summary, The dollar cost of the increase in sexually transmitted diseases exceeds the cost of all US wars and, if not too rigorous a connection is demanded, can be shown to exceed the

national debt. The number of infected exceeds the number of casualties in all our wars by perhaps ten to one. The number killed is now a large fraction of the number killed in our wars and is likely to exceed the number killed in all our wars by the year 2000.

In a relatively disease free nation, the one night stand is relatively safe because one catches sexually transmitted diseases from one's partner. If only one percent of potential partners who sleep around are infected, one would have to have sex with about 50 before being exposed to the potential of a sexually transmitted disease. In practice, the odds are even better, because even if unprotected, one might not catch the disease. In addition, condoms might help a little (but only a little. Condoms are not even 90% effective in preventing

conception over the course of a year. The sperm is far larger and easier to stop via a barrier than many disease causing agents and a woman is only fertile a short time each month. This indicates that condoms should not be relied on to stop sexually transmitted diseases. This is in accord with the data. Condom sales this decade were the greatest in history and they apparently did little to slow the spread of sexually transmitted diseases.)

We are now in a situation where some people sleep around and others do not. Those who were virgins before marriage and are loyal afterwards are seldom infected, although they could have had the bad luck to marry an infected person. Those who only sleep around a little are less likely to be infected than those who sleep around a lot. Now if you go to bed

with a stranger, which of the preceding is it likely to be? Of course, the person who will go to bed with you is far more likely to have gone to bed with others. You are, for disease catching potential, going to bed with everyone your partner has previously slept with. Considering 20,000,000 or more infected with certain sexually transmitted diseases, this may include nearly everyone likely to share a one night stand with you. The practical effect is that if you play, you are going to pay.

Of course, this Court is not the sole cause of the sexual revolution. It is, probably the primary cause directly and indirectly via the licence it has given the media. There used to be censors who limited the media. This Court killed that concept and so has been a proximate cause of the sexually arousing material we now

call TV, Movies, books, etc. This Court did not invent the pill, but this Court poured gasoline on the spark the pill ignited.

Accordingly, by its right to privacy and freedom of sexually suggestive or explicit speech decisions, this Court has killed the previously effective opposition and unleashed the sexual storm that is wreaking havoc today.

NON DISEASE PROBLEMS

The damage to America related to the sexual revolution goes far beyond sexually transmitted diseases. A substantial minority still clings to the Judeo Christian ethic which protects them from the worst of the storm. The majority which have no strong religious protection bear the brunt.

The divorce rate is now so high that half of this years marriages will

probably end in divorce. The cost of all the true love that could not happen is high. The suicide rate is down, except among the youth which pays the highest price for the sexual freedom this Court has sold. Illegitimacy is way up, three times as high as a generation ago, with 60% of black children born out of wedlock. The cost of this illegitimacy in increased welfare roles and decreased production from children damaged by lack of a father and two parent home exceeds the national debt. There are lots of subtle costs. How about the "good kid" who is afraid to date or party because of the one night stand expectation? How about the kids who suffer through divorce or near divorce. How about all the marriages held together but just barely because one partner lacks commitment?

There used to be this thing called

commitment. Some would say it was the opposite of freedom. I say it is the fulfillment of freedom. This Court's decisions have made commitment harder to find and harder to give. Abortion is the ultimate denial of commitment.

As if that were not enough, the forces unleashed by this Court and its allies are destroying Western Civilization. The future belongs to the descendants of those who have children. This is an obvious statement. Who is having children? Not the descendants of our peers. Our old America is not reproducing itself. The percentage of residents of America whose parents were born in Mexico is greater than it was when much of America was ruled by Mexico. I am certain the future culture which will descend from this change will have many good points, but it will not be the

Western Civilization that did so much for the world in recent years and centuries. I think the passing of that culture is regrettable.

Any public health specialist could go on for volumes discussing these or related problems. We will spare you and trust that this brief will remind you of many of the things you must have observed which are fairly common knowledge. The saddest proof that the right to privacy and related decisions of this Court which have let the sexual monster out of the bottle is that the penalties have fallen in proportion on those who have taken most advantage of the "freedom" (some would say licence) this Court unleashed on an America unable to digest them without severe disproportionately great agony.

CONCLUSION

Would that this Court had given greater thought to the story of Pandora's Box before launching America on this journey from the land of commitment to the land of sexual freedom from everything except sexually transmitted disease. After all the troubles, there was one thing left in the box, hope. I hope you reverse the right to privacy and once more encourage true lasting love and commitment.

Respectfully submitted,

ROBERT L SASSONE, Attorney for Amicus

APPENDIX 1

THE ECONOMIC COST OF PELVIC INFLAMMATORY DISEASE by A Eugene Washington, MD; Peter S Arno, PhD; Marie A Brooks, MBA
JAMA 4/4/86 Vol 255 No 13

PELVIC inflammatory disease (PID), the most common serious complication of sexually transmitted diseases, is a medical and public health problem that has risen to alarming proportions. Each year more than 1 million women in the United States experience an episode of PID, with at least one fourth of them suffering one or more serious long-term sequelae. Acute PId increases a woman's risk for recurrent PID, chronic pelvic pain, ectopic pregnancy, and infertility. Risk for both ectopic pregnancy and infertility increase sevenfold after one episode of PID. Dyspareunia, pelvic adhesions, pyosalpinx, inflammatory residua, and tubo-ovarian abscess may also follow.

Overall, such complications occur in approximately 15% to 20% of cases and often require subsequent surgical intervention. These troublesome medical consequences of PID are often associated with great emotional stress, can have a major effect on a woman's sexual as well as reproductive health, and can threaten her fertility.

Economically, PID and its consequences also represent a substantial burden. NEARLY 300,000 women are hospitalized annually for PID, and women make over 2.5 million outpatient visits for PID each year. In addition to these sizable direct medical costs are indirect costs due to lost wages and the lost value of household management. Too often, these indirect costs are overlooked when considering the economic burden of illness to individuals.

In this article, we estimate the direct and indirect cost for PID and PId-associated ectopic pregnancy and infertility in the United States for 1984 and project costs through 1990.

METHODS DIRECT COST

"Direct cost" in our analysis refers to health care expenditures and represents the value of goods and services actually used to treat PID or its effects. Charges for medical care are used to approximate cost.

PID.-We examined the bills of women admitted to two hospitals in San Francisco for PID to estimate the average cost of hospitalization. Bills from hospital A covered women admitted between August 1983 and July 1984 (N=54); those from hospital B covered admissions from September 1982 through August 1983 (N=35). Estimates based on local

data were then compared with averages computed using data from state and national sources. We used average cost per admission at hospital A ($2,865) in our analysis because it was the lowest estimate of all sources and one of the most current.

For outpatient PID, we estimated average cost per visit (including cost of office visit, laboratory tests, and drugs) to be $60, based on data from the American Medical Association and the Health Care Financing Administration. We assumed 2.5 outpatient visits per case of PId. Our total average cost of $150 for outpatient PID is close to the average cost of $180 obtained from national sources. Surgical procedures resulting from an acute episode of PID average a minimum $1,250 at hospital A. This figure represents the minimum charge

for use of the operating room and the recovery room, plus fees for surgery and anesthesiology.

Ectopic Pregnancy.-We estimated the average cost for hospitalization for ectopic pregnancy to be $4,115 by adding the average cost of a surgical procedure ($1,250) to the average cost of hospitalized PID ($2,865). Outpatient visits for ectopic pregnancy average the same cost as for out-patient PID ($60). We assumed two visits per case- one before and one after hospitalization.

Infertility.-We estimated the average cost of a complete infertility evaluation and management (including laparoscopy, microsurgery, and possible in vitro fertilization) to be $2,500. Assuming that 10% of women with PID-related infertility seek medical care, we conservatively

computed an average cost of $250 for PID-associated infertility consultations. This relatively low estimate for infertility consultation is used because the precise cost of infertility is difficult to determine.

INDIRECT COST

"Indirect cost" in our analysis refer to lost productivity and represents the value of output foregone by women suffering from PID, PID-associated disability (ectopic pregnancy or infertility), or premature death caused by PID. Indirect costs are measured by lost wages due to not working and/or the value of household management that is not performed because of illness. Complete descriptions of the methods for computing indirect costs of illness have been published else-

where.

Lost Wages-Total wages lost were calculated by multiplying four variables for each condition and age group: (1) mean annual earnings, (2) percent of women with earnings, (3) disability factors, and (4) number of cases. Mean annual earning for women ages 15 to 44 years and the percent of women with earnings in this same age group were obtained from published data. To compute a disability factor, we divided the number of working days a woman was disabled by the number of working days in a calendar year (245). Assuming ten days of disability for outpatient PID, 21 for hospitalized PId, 28 for ectopic pregnancy, and 14 for infertility, we computed disability factors of 0.041, 0.086, 0.114 and 0.057, respectively. The methods for estimating the number of cases are

described below.

Lost Value of Household Management.- the total lost value of household management was also computed by multiplying four variables for each condition and age group: (1) mean annual value of household management for employed and unemployed women, (2) percent of women with and without earnings, (3) disability factors, and (4) number of cases. The mean annual values of household management for employed and unemployed women were computed by multiplying hours spent in each kind of domestic tack by the wages for corresponding occupations.

Lost Value of Lifetime Earning From Deaths.-the present value of lifetime earnings was obtained from published data. we selected the median value for women

aged 15 to 44 years because the age at death is not known. A discount rate was used to convert a future stream of earnings into its present worth. Discounted at 4%, the present value of lifetime earnings is $395,649 per person, and discounted at 6% the value is $301,570. The later is used in our baseline analysis. Estimates of the annual number of deaths among women hospitalized for PID range from 150 to 1,200, we used the mean of these two points (675) in our analysis. Twenty-four maternal deaths occur annually among women with PId-associated ectopic pregnancy.

Incidence estimates

Pelvic Inflammatory disease.-The numbers of women hospitalized for PID and number of PID-associated surgical procedures are based on

published data from the Hospital Discharge Survey conducted by the National Center for Health Statistics. For outpatient PID, we analyzed published data from National ambulatory Medical Care Survey to calculated visits to office-based physicians (1,744,700) and from the National Heath Survey of Physician Visits to estimate the number of visits to clinics and emergency rooms (768,700).

Ectopic Pregnancy.-Incidence estimates for ectopic pregnancy are from published data from the Hospital Discharge Survey. Based on attributable risk estimates, we assumed 50% of morbidity and mortality of ectopic pregnancy is caused by PID.

Infertility.-Using data from a study of women with laparoscopically verified

salpingitis followed up for ten years, we assumed that 20% of the approximately 1 million women with PID each year will become infertile.

RESULTS - Direct Cost

Total direct costs for PID and PID-associated ectopic pregnancy and in fertility are estimated to be $1.23 billion. The direct cost of PID alone accounts for 87% of that total. Hospitalized care for PID represents 72% of overall Pid costs and 62% of total direct cost. Ectopic pregnancy that is associated with PID accounts for 90& of total direct cost. Hospitalized care for PID-associated ectopic pregnancy represents 97% of the overall cost of PID-associated ectopic pregnancy and 8.8% of the total direct cost. Infertility accounts for 4.1% of the total direct cost.

RESULTS - Indirect Cost

Indirect costs of PID, PID-associated ectopic pregnancy, and infertility are estimated to total $1.39 billion. Indirect costs due to lost wages represent 35% of the total indirect cost, with PID itself accounting for 79% of overall lost wages and 28% of total indirect cost. Lost value of household management accounts for 50% of the total indirect cost, with PID representing 78% of the overall lost value of household management and 39% of the total indirect cost. Ectopic pregnancy, infertility, and premature death account for 4.9%, 13.4%, and 15.2%, respectively, of the total indirect cost.

RESULT - Projection Through 1990

By 1990, the estimated cost of PID and associated ectopic pregnancy and infertility will total $3.50 billion per year, assuming the annual medical care inflation of 5% and the incidence of PID

remain constant during this period. (The annual average percentage change in inflation for medical care services between 1980 and 1984 was 9.8%.) If the rate of PID increases by 1% per year, the total cost will exceed $3.72 billion annually by 1990. With a 1% decline in incidence each year, the cost of PID and its associated sequelae will still reach $3.3 billion per year by 1990. For the total cost of PID to drop below $2 billion by 1990, (with a constant medical care inflation rate of 5%), the incidence of PID would have to decline annually by about 10%. Such a decline could result in a savings of $1.86 billion in 1990 alone, and $6.44 billion during the six-year period from 1984 to 1990.

COMMENT

Our analysis indicates that PID and its sequelae cost more that $2.6 billion each year, placing a substantial economic burden on society. It is Important to note that this figure may, in fact, underestimate the cost of PID and PID-associated ectopic pregnancy and infertility for several reasons. First throughout this analysis we used conservative figures. The direct costs of infertility, in particular, may be markedly underestimated given the increasing demand for infertility consultation an the emergence of sophisticated but expensive, new techniques for infertility management. Moreover, no indirect costs were included for male partners of women undergoing infertility evaluation, although they are included in the medical evaluations, and no direct or indirect costs were calculated

for infertility caused by asymptomatic (and unrecognized) PID.

Second, our incidence data do not reflect the most recent trends for the majority of the outcomes we examined. For example, the more recent data on ectopic pregnancy show a 23% increase in the annual incidence for 1983 over the figure we used form 1980, as well as increases in the rates of hospitalization for PID (Centers for Disease Control, unpublished data, 1985). Third only women aged 15 to 44 years are included in this analysis. Although firm data are not available, rates of sexually transmitted diseases may be rising among teenagers younger than 15 years, and these girls may be experiencing PID and its sequelae at an increasing rate. Women older than 44 years also contribute marginally to the acute problem and

may suffer some chronic sequelae requiring hospitalization and surgery. Exclusion of women at both extremes contributes to an underestimation of the overall cost. Finally, psychosocial cost are not included for PID, ectopic pregnancy (with its resultant fetal loss), of infertility. Each of these may be a major life event with an incalculable impact on an individual or family.

Compared with a recent analysis, our estimated direct costs are lower when direct costs of only gonococcal PID, ectopic pregnancy, and infertility from that report are extrapolated to all PID, ectopic pregnancy, and infertility ($1.23 vs $1.93 billion). The difference observed in these two estimates is accounted for by the higher estimate of hospitalized PID

cost ($0.91 vs $1.38 billion) and the substantially higher estimate of infertility cost ($50 vs $335 million) in the previous report. Another estimate of the total cost for PID and associated ectopic pregnancy made five years ago was lower that ours ($1.26 vs $2.38 billion). Most of this difference is accounted for by lower estimates of average hospital cost and number of cases for both PID and ectopic pregnancy used in the earlier analysis. Thus, considering these two comparisons and the methodological concerns raised above, our cost estimate seems reasonably to approximate the lower range of the true economic burden of PID in the United States in 1984.

Trends in PID closely shadow those of sexually transmitted diseases. Rates

of sexually transmitted diseases have risen among adolescents, as have PID rates. In fact, sexually active adolescents, who have the most reproductive years at risk, are almost ten times as likely to develop PID as women aged 20 years or older. Chlamydia trachomatis has emerged as the most prevalent bacterial sexually transmitted disease in the United States and is now also the leading cause of nongonococcal PID. This organism is a cause of asymptomatic disease in up to 70% of lower genital tract infections in women. An equal number of cases of tubal damage and infertility may be caused by clinically inapparent C trachomatis infection. Consequently, improved knowledge about sexually transmitted diseases, especially regarding risk factors for development of PID and its sequelae, and application of that

knowledge to demonstrated control strategies for sexually transmitted diseases should be supported. Prevention of lower genital tract sexually transmitted diseases, as well as arresting their ascension to vulnerable upper genital tract organs, remains the most cost-effective approach to reducing the incidence of and large investment of PID.

In summary, PID is clearly a major public health problem, with serious economic as well clinical and emotional implications. The rising costs of PID can be interrupted by establishing and maintaining effective prevention and control programs for PID and sexually transmitted diseases; such efforts could by 1990 save nearly $2 billion in that year alone. Clinicians must understand the risk factors for development of PID, maintain a higher index of suspicion for the wide range

of clinical presentations associated with PID, and provide timely, effective treatment to patients and to their sex partners.

APPENDIX 2

'SILENT EPIDEMIC' OF 'SOCIAL DISEASE' MAKES STD EXPERTS RAISE THEIR VOICES

by Marsha F Goldsmith JAMA June 23/30 1989 Vol 261, No 24

Immunological virgins seem to be almost the only kind one finds among adolescents anymore, and that fact may in part account for the tremendous increase in sexually transmitted diseases (STDs) in the United States.

At a symposium in New York City on "The 'Other' STDs: A Silent Epidemic," sponsored by the American Medical Association and the Centers for Disease Control (CDC), Atlanta, Ga, authorities who have worked on stopping STD spread for years said the situation is now nearly out of control.

("Other" recognizes that acquired immunodificiency syndrome (AIDS) has become the overwhelming concern, leaving different STDs in the shade. The meeting was supported by a grant from Burroughs Wellcome Company.)

A major reason for STD increase is that young people are being exposed to infection, and acquisition is often rapid and symptomatic. A great many of the more than 70% of people who are sexually active by age 19 years may have an initial exposure to an STD, become infected, and pass the infection on without ever feeling ill or knowing they've been infected.

Only years later – when gonorrhea and/or *Chlamydia* have left scarred Fallopian tubes that may mean an ectopic pregnancy, or human papillomavirus (HPV) or hepatitis B virus has led to cancer, or genital herpes or syphilis has resulted in a damaged infant – may the cost of careless sex become apparent.

And that's exactly what is going on, state the experts. "We have to think seriously about this or we're going to have an entire infertile cohort," says Mary Ann Shafer, M.D., assistant director, Division of Adolescent Medicine at the University of California, San Francisco, School of medicine.

According to John LaMontagne, Ph.D., director of the Microbiology and Infectious Diseases Program at the National Institute of Allergy and Infectious Diseases (NIAID), Bethesda, Md, these are the best estimates of what else is happening: Each year in the United States, there occur 1 to 2 million new cases of gonorrhea, 4 million new cases of chlamydial infection, and 500,000 to 1 million new cases of pelvic inflammatory disease. There are 12 million cases of genital warts (caused by

HPV), with 750,000 new ones per year, and 20 to 30 million cases of symptomatic genital herpes infection (herpes simplex virus type 1 or 2 [HSV-1 or 2]), with 500,000 new ones per year.

Yvonne Bryson, M.D. associate professor pediatrics, University of California, Los Angeles, School of Medicine, says new studies show there are many more cases of asymptomatic genital herpes infection. "I don't think most obstetricians are aware of this yet," she says, citing some startling figures.

In Atlanta, Los Angeles, and Seattle, Wash, says Bryson, as many as 65% of pregnant women may have "silent" HSV-2 infection. While women known to have genital herpes are well managed, "the problem is the women, and their doctors, who don't know." Bryson says, "There should be a push of development of

screening tests. We may have to change our thinking about general screening during pregnancy."

Syphilis accounts for about 100,000 new STD cases annually - including congenital cases, which rose fourfold in the 3 years 1985 through 1987 and continue to go up.

According to King K. Holmes, M.D., Ph.D., professor and vice-chair, Department of Medicine, University of Washington School of medicine, Seattle, syphilis is up twofold among black men and up threefold among black women. Gonorrhea is 20 times higher in blacks than in whites. Specific figures were unavailable on Hispanics, but it's known that STDs occur disproportionately among lower socioeconomic groups, primarily among blacks and Hispanics.

That's true even after correcting for reporting bias, which occurs because of how data are gathered, says Willard Cates, M.D. M.P.H., director, Division of Sexually Transmitted Diseases, at the Centers for Disease Control. That agency collects its data from the states and Cates says physicians underreport. Up to 80% of reports come from public STD clinics and fewer than 20% come from private physicians. In reality, he says, the occurrence of these diseases among public and private patients is probably equal. But many more poor people have turned to public clinics for STD treatment, and clinics report scrupulously.

Now that's changing, said Holmes. Public health clinics can no longer afford to handle the overwhelming caseload. They close earlier, waiting time is

longer, and people who most require their services don't have access to care.

Holmes said he thinks the most practical strategy for coping with the STD epidemic in populations at high risk is to establish high school-based sex education programs that include treatment clinics. "We don't know what behavioral interventions work, and the crack-using population [who exchange sex for drugs] isn't very well studied, but we've got to treat this epidemic," he says.

According to Shafer, the *Chlamydia* epidemic is even worse. She said that in many parts of the country, "infection is extremely common and entirely undetected." *Chlamydia* is the most prevalent STD in young women, affecting 15% to 20% (three to five times the rate for gonorrhea), and is mostly asymptomatic. And

9% to 11% of young men have asymptomatic infection, she says.

It's time to reevaluate STD prevention programs, traditionally geared to females, said Shafer, adding, "It's easy to screen males using a leukocyte esterase test that can be one on a urine specimen for 20 cents a stick." She believes "we should be treating all sexually active men. But we also need a better treatment for *Chlamydid*. We have to tell patients, 'Take this medicine for 7 days and you'll feel nauseated.' How can we get teenagers to do that when they don't even realize they're ill?"

Shafer doesn't believe more research will solve all the problems, because "we're dealing with the interaction of biology and behavior. No matter how much money we pour into studies, we'll never completely control STDs medically because

there'll always be a new one. The bottom line is changing behavior."

The same thing is said about AIDS, of course. Now, much more federal funding is directed toward AIDS research than toward the "other STDs." This year the NIH has almost $604 million for AIDS. All other STDs combined are allocated $60 million. (Next year, the AIDS figure is more than $750 million and for other STDs, about $65 million.) The NIAID gets about $40 million of the NIH's annual "other STD" budget, and spends about one third of the amount on herpesvirus research. (Gonorrhea is second and *Chlamydia* third.) Several other institutes share the total, notably the national Cancer Institute, which studies the many varieties of HPV, three types of which are believed to be the principal cause of genital cancers. LaMontagne

said, "Despite the need, the NIH money spent on STDs has not greatly increased. The pattern of support is unchanged over the last decade."

The NIAID has made substantial accomplishments in studying STDs. It has supported research to improve diagnosis of chlamydial infection using hybridization techniques, and investigators at its Rocky Mountain Laboratory have made progress toward developing chlamydial vaccines. With the National Institute of Child Health and Human Development, it has begun a study on vaginal infections and prematurity.

The institute has pioneered in developing model systems to propagate HPV, supported research that led to using the polymerase chain reaction for diagnosing HPV infections, and established the value of interferon for treating them. This is

of particular interest to Thomas Becker, M.D., Ph.D., assistant professor of medicine at the University of New Mexico School of Medicine in Albuquerque. Although genital HPV infection is extremely common, Becker said, and more than 60 types of the virus have been identified, scientists still have more questions than answers about these viruses.

Known risk factors for acquiring HPV include having multiple sexual partners, using oral contraceptive pills, being immunocompromised, and smoking cigarettes. Becker says, "Treatment for the lesions has been suboptimal, which is frustrating for the physician and the patient." Add to this worry about the cancer connection, and Becker says, "HPV infection will be of growing concern in the next 3 years."

Another viral disease ought to be of increasing concern now, thinks Miriam Alter, Ph.D., chief of Surveillance Activity, Hepatitis Branch, in the CDC's Division of Viral Diseases. A recent study showed that only 10% of physicians recognize heterosexual activity as a risk factor for hepatitis 2, she says. But each year, 78,000 cases occur that way, of which 6000 will result in chronic disease and 1600 in death. Alter is angry because all this illness is preventable.

Wendy Wertheimer, deputy executive director of the American Social Health Association, began her presentation with the telephone number of its national STD hotline (1-800-227-8922). Knowing it is probably a good idea because, Wertheimer said, considering the size of the problem in relation to the money being spent to find a solution, "We're trying to contain

a 4-alarm fire with a few buckets of water."

She said the association is calling for a "dramatic increase" in federal and state funding, and decried the fact that the issue "has become so politicized, reflecting a national fear of sex." Moreover, said Wertheimer, medical schools have an "abysmal record" in training their students to deal with STDs, and the present lack of funds for training resident physicians will make providing needed care even more difficult.

NO 88-1125
IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

JANE HODGSON, MD, ET AL.
Petitioners,
v.
THE STATE OF MINNESOTA, ET AL.
Respondents,

Affidavit of mailing of amicus brief copies, Rule 28.2
State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:
Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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_____
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Subscribed and sworn to before me on October 11, 1989.

_____
Lawrence D. Sassone, Notary Public